TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
GLOBAL MOLECULAR LABS

Respondent Name
TASB RISK MGMT FUND

MFDR Tracking Number
M4-17-2963-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
June 8, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The charges referenced herein were filed with the Carrier and denied for 'pre-certification or authorization or notification absent.' We have requested reconsideration from the carrier and they are maintaining the rationale. We believe this claim has been denied arbitrarily and respectfully request dispute resolution in this matter."

Amount in Dispute: $6,250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Fund denied the bill for absence of preauthorization as the services billed are outside the Official Disability Guidelines, (ODG) per rule 134.600 and 137.100, lack of supporting documentation."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 9, 2016	G0483	$6,250.00	$269.04

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 197 – Payment adjusted because for absence of precertification/authorization/notification. Per Rule 134.600 treatment provided after May 1, 2007 must be in accordance with the Official Disability Guidelines. The only indication for doing definitive drug testing would be for those drugs that are currently prescribed to the patient or have tested positive on presumptive testing. The only drug call that would be counted, based on what has been prescribed or have tested positive on presumptive testing, would be this code is not supported
    - 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.
    - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Did the requestor meet division documentation requirements?
2. Are the insurance carrier's denial reasons supported?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied HCPCS Code G0483 rendered on November 9, 2016 with denial reason codes "150 – Payment adjusted because the payer deems the information submitted does not support this level of service."

   The Division finds that the process for a carrier's request of documentation not otherwise required by 28 Texas Administrative Code §133.210 is detailed in section (d) of that section, "Any request by the insurance carrier for additional documentation to process a medical bill shall: (1) be in writing; (2) be specific to the bill or the bill's related episode of care; (3) describe with specificity the clinical and other information to be included in the response; (4) be relevant and necessary for the resolution of the bill; (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider; (6) indicate the specific reason for which the insurance carrier is requesting the information; and (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation".

   No documentation was found to support that the carrier made an appropriate request for additional documentation during the medical bill review process with the specificity required by rule. The division concludes that carrier failed to meet the requirements of 28 TAC 133.210(d).

2. The insurance carrier denied HCPCS Code G0483 rendered on November 9, 2016 with denial reason codes "197 – Payment adjusted because for absence of precertification/authorization/notification. Per Rule 134.600 treatment provided after May 1, 2007 must be in accordance with the Official Disability Guidelines. The only indication for doing definitive drug testing would be for those drugs that are currently prescribed to the patient or have tested positive on presumptive testing. The only drug call that would be counted, based on what has been prescribed or have tested positive on presumptive testing, would be this code is not supported."

   28 Texas Administrative Code §134.600(p)(12) states in pertinent part "(p) Non-emergency health care requiring preauthorization includes: (12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits)."

   HCPCS Code G0483 is defined as "Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to, GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)), (2) stable isotope or other universally recognized internal standards in all samples (e.g., to control for matrix effects, interferences and variations in signal strength), and (3) method or drug-specific calibration and matrix-matched quality control material (e.g., to control for instrument variations and mass spectral drift); qualitative or quantitative, all sources, includes specimen validity testing, per day; 22 or more drug class(es), including metabolite(s) if performed."

   28 Texas Administrative Code (TAC) §137.100 (a) states, in pertinent part, "Health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines - Treatment in Workers' Comp..."* Health care provided in accordance with the Division treatment guidelines is presumed reasonable as specified in Labor Code §413.017, and is also presumed to be health care reasonably required as defined by Labor Code §401.011(22-a).

Review of the 2016 ODG pain chapter under the "Drug testing" finds that drug testing is recommended. The division concludes that the services were provided in accordance with the division's treatment guidelines; and that the services are presumed reasonable pursuant to 28 TAC §137.100(c), and Labor Code §413.017; and are also presumed to be health care reasonably required as defined by Labor Code §401.011(22-a).

For the reasons stated above the Division finds that insurance carrier's denial reasons are not supported and the requestor is entitled to reimbursement for the services in dispute.

3. The service in dispute is HCPCS Code G0483 for clinical laboratory services subject to 28 Texas Administrative Code §134.203 (b) which states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   28 Texas Administrative Code §134.203 (e) states in pertinent part, "The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and (2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service."

   Reimbursement is determined pursuant to Medicare's 2016 Clinical Laboratory Fee Schedule found at, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/ and calculated as follows:

   Procedure code G0483, service date November 9, 2016, represents a lab service paid per Rule §134.203(e). The Medicare Clinical Lab Fee is $215.23 x 125% = a MAR amount of $269.04. Therefore, this amount is recommended.

4. Review of the submitted documentation finds that the requestor is entitled to reimbursement in the amount of $269.04. Therefore, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $269.04.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $269.04 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		July 6, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.